STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HOSPITAL & HEALTH SERVICES	2001 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This is a State hospital complaint investigation. Dates of Survey: 08/16/2012 Facility Number: 005075 Complaint # IN00108924 Unsubstantiated; Lack of sufficient evidence. Surveyor : Albert Daeger, Medical Surveyor St. Vincent Hospital & Health Services is in compliance with 410 IAC 15-1.5-2, Infection control, 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules. QA: claughlin 08/22/12	S 000		